

**United States Department of Labor
Employees' Compensation Appeals Board**

_____)	
T.C., Appellant)	
)	
and)	Docket No. 17-1906
)	Issued: May 25, 2018
DEPARTMENT OF THE AIR FORCE,)	
ELLSWORTH AIR FORCE BASE, SD,)	
Employer)	
_____)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On September 11, 2017 appellant filed a timely appeal from a May 2, 2017 merit decision and an August 31, 2017 nonmerit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act¹ (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to consider the merits of the case.

ISSUES

The issues are: (1) whether appellant has established more than nine percent permanent impairment of his right lower extremity, for which he previously received a schedule award; and (2) whether OWCP properly denied appellant's request for reconsideration of the merits of the claim pursuant to 5 U.S.C. § 8128(a).

¹ 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

This case has previously been before the Board.² The facts as presented in the prior appeal are incorporated herein by reference. The relevant facts are as follows.

On September 19, 2011 appellant, then a 56-year-old financial specialist, filed a traumatic injury claim (Form CA-1) alleging that he fractured his right femur and dislocated his right hip when he tripped and fell on September 6, 2011 in the employing establishment parking lot. He stopped work the same day and later returned to work on October 31, 2011. OWCP accepted the claim for peri-prosthetic fracture right femur and closed fracture of the shaft of the right femur on November 1, 2011.

On September 8, 2011 appellant, who has a history of cerebral palsy as well as multiple bilateral lower extremity surgeries and ambulates with crutches, underwent an open reduction and internal fixation of his right femur fracture. The fracture occurred near the tip of his one-month-old right total hip arthroplasty. Appellant received a locking plate and multiple proximal locking screws and cables with distal locking and unlocking screws in his right femur. He also has had a left total hip arthroplasty

Appellant underwent a magnetic resonance imaging (MRI) scan of this right knee on October 25, 2011 which demonstrated high-grade patellofemoral and lateral femoral condyle chondromalacia with diffuse thinning of the weight bearing medial femoral condyle cartilage. It also demonstrated a tear in the lateral meniscus and chronic sprain of the medial collateral ligament as well as a Baker's cyst. A bone scan on June 12, 2013 demonstrated possible loosening of the femoral component of the right hip arthroplasty.

On April 21, 2014 OWCP referred appellant for a second opinion evaluation with Dr. Lawrence G. Splitter, an osteopath Board-certified in preventative medicine. In his May 16, 2014 report, Dr. Splitter described appellant's history of injury and noted that appellant had residual decreased tolerance and endurance in his right leg. Appellant currently required a three centimeter shoe lift and an additional crutch. Dr. Splitter reported appellant's right thigh measurement of 43 centimeters and his left of 42.5 centimeters. Appellant's right calf was 32 centimeters while his left was 33.5 centimeters. His right leg was 87 centimeters long while his left was 90 centimeters. Appellant demonstrated active range of motion in the right hip 50 degrees of flexion and 0 degrees of extension. His right hip abduction was 20 degrees while his adduction was 30 degrees. Dr. Splitter could not measure appellant's internal and external rotation due to appellant's inability to lie flat on the examination table. He found full strength across the right hip. Dr. Splitter reported appellant's right knee motion as 90 degrees of flexion and negative 20 degrees of extension. He indicated that appellant's gait was scissoring due to cerebral palsy and was assisted with bilateral crutches. Dr. Splitter found increased muscle tone throughout the lower extremities. He noted that appellant's reflexes were present and symmetric at L4 and L5 and absent at S1. Dr. Splitter found that appellant had reached maximum medical improvement

² Docket No. 16-1067 (issued November 16, 2016).

(MMI). He applied the A.M.A., *Guides* sixth edition³ and found that appellant had eight percent of the lower extremity due to his proximal femur fracture due to malalignment.

On August 5, 2014 appellant filed a claim for compensation (Form CA-7) and requested a schedule award. OWCP's medical adviser reviewed the case record on August 8, 2014 and found no malalignment, but identified mild motion loss and determined that appellant had nine percent permanent impairment of his right lower extremity.

By decision dated August 13, 2014, OWCP granted appellant a schedule award for nine percent permanent impairment of his right lower extremity.

Appellant requested reconsideration on January 27, 2016. He argued that his impairment was greater than that awarded by OWCP. Appellant described his loss of motion, pain and weakness, deformity, loss of strength, sensitivity to heat and cold, as well as scarring. He asserted that he now used a wheel chair at work to perform normal daily functions. Appellant alleged additional impairment due to his limb length discrepancy. He asked that OWCP notify him if additional information was needed. Appellant resubmitted Dr. Splitter's May 16, 2014 report. He also submitted information from a website regarding schedule awards and amended schedule awards.

By decision dated February 3, 2016, OWCP found that appellant's request for reconsideration was untimely filed and failed to demonstrate clear evidence of error.

On April 25, 2016 appellant filed a timely appeal to the Board. In its November 16, 2016 decision,⁴ the Board remanded the case finding that appellant was requesting an additional schedule award rather than requesting reconsideration which OWCP found to be untimely filed. The Board directed OWCP to undertake further development of the issue of whether appellant had permanent impairment of his right lower extremity entitling him to an additional schedule award.

On January 24, 2017 Dr. Jeff Marrs, a Board-certified orthopedic surgeon, completed a treatment note regarding appellant's ongoing bilateral hip pain. He found tenderness over the inguinal crease and discomfort with external motion in the right hip and in the left hip tenderness over the anterior thigh just distal to the joint. Dr. Marrs reviewed appellant's hip x-rays and found that total hip components were in the correct place with no sign of failure or loosening. He diagnosed iliopsoas tendinitis. On April 10, 2017 Dr. Marrs examined appellant due to his bilateral hip pain. He opined that appellant's pain was due to his hip replacements and diagnosed iliopsoas tendinitis. Dr. Marrs recommended a bone scan which appellant underwent on February 13, 2017. This scan demonstrated a persistent uptake surrounding the hardware of the right femur from the total hip replacement with possible loosening of the component.

Following the Board's decision, OWCP referred appellant for a second opinion evaluation with Dr. Michael C. Kaplan, a Board-certified physiatrist with questions for resolution. Dr. Kaplan was specifically asked whether MMI had occurred, the diagnosis upon which

³ A.M.A., *Guides* (6th ed. 2009).

⁴ *Id.*

permanent impairment was based, and, a detailed description of permanent impairment. He completed a report on February 23, 2017 and noted that appellant currently required a wheelchair and had decreased ability to perform activities of daily living. Dr. Kaplan provided range of motion figures for appellant's hips bilaterally as 65 degrees of flexion, while on the right appellant had 20 degrees flexion contracture. Appellant indicated that he experienced pain with passive rotation at the right hip. Dr. Kaplan found that right hip abduction was 20 degrees as was adduction. Appellant's right quadriceps was 43 centimeters while his left was 42. Dr. Kaplan found bilateral hip flexor strength of 4+/5 with brisk reflexes. He also reported difference in leg length with accommodating pelvic shift. Dr. Kaplan reported a six centimeter difference. He noted, "I have seen studies completed for the case including some of the serial bone scans which have provided some suggestion that there could be loosening of the hip replacement." Dr. Kaplan further noted that the medical record did not contain a definite statement at all aspects of the hardware and other aspects of appellant's hip replacement were without concerns regarding stability or loosening. He found that appellant had experienced a functional decline. Dr. Kaplan determined that until there was a "definite subspecialty conclusion that the total hip replacement is satisfactory," appellant was not at MMI for schedule award purposes.

By decision dated May 2, 2017, OWCP denied appellant's claim for an additional schedule award finding that he had not reached MMI based on Dr. Kaplan's report.

In a letter dated May 16, 2017, appellant requested clarification of the May 2, 2017 OWCP decision. He alleged that his condition warranted an additional schedule award due to the change in his leg lengths which resulted in discomfort in his hips. Appellant resubmitted the February 13, 2017 bone scan on May 3, 2017. On May 5, 2017 he underwent bilateral iliopsoas bursa steroid injections. Appellant provided notes from Corey Anderson, a physician assistant, dated May 25, 2017. He requested reconsideration of the May 2, 2017 OWCP decision on June 9, 2017 and noted that he believed he was entitled to an increased schedule award for his right leg due to changes in his limb length discrepancy found by Drs. Splitter and Kaplan.

By decision dated July 6, 2017, OWCP accepted the additional condition of right hip bursitis. It listed appellant's accepted conditions as fracture of the neck of the right femur, strain of the right pelvis, stress fracture of the right femur, bursitis of the right hip, peri-prosthetic fracture around prosthetic joint on the right, and closed fracture of the right femur.

By decision dated August 31, 2017, OWCP denied appellant's request for reconsideration.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of FECA⁵ and its implementing regulations⁶ set forth the number of weeks of compensation payable to employees sustaining permanent impairment for loss or loss of use, of scheduled members or functions of the body. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the discretion of OWCP. For consistent

⁵ 5 U.S.C. §§ 8101-8193, 8107.

⁶ 20 C.F.R. § 10.404.

results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. OWCP evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the A.M.A., *Guides*, published in 2009.⁷

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).⁸ In addressing lower extremity impairments, the sixth edition requires identifying the impairment Class of Diagnoses (CDX) condition, which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).⁹

OWCP procedures provide that, to support a schedule award, the file must contain competent medical evidence, which shows that the impairment has reached a permanent and fixed state and indicates the date on which this occurred (date of MMI), describes the impairment in sufficient detail so that it can be visualized on review and computes the percentage of impairment in accordance with the A.M.A., *Guides*.¹⁰ MMI means that the physical condition of the injured member of the body has stabilized and will not improve further.¹¹ The determination of MMI is not to be based on surmise or prediction of what may happen in the future. A schedule award is appropriate where the physical condition of an injured member has stabilized, despite the possibility of an eventual change in the degree of functional impairment in the member.¹² The question of when MMI has been reached is a factual one which depends on the medical findings in the record and the determination of such date is made in each case upon the basis of submitted medical evidence.¹³

ANALYSIS -- ISSUE 1

The Board finds that this case is not in posture for decision.

⁷ For new decisions issued after May 1, 2009 OWCP began using the sixth edition of the A.M.A., *Guides*. A.M.A., *Guides*, 6th ed. (2009); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.5a (March 2017); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010).

⁸ A.M.A., *Guides* 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement (6th ed. 2009); *B.A.*, Docket No. 17-1360 (issued January 10, 2018).

⁹ *Id.* at 521. *J.B.*, Docket No. 09-2191 (issued May 14, 2010).

¹⁰ Federal (FECA) Procedure Manual, *supra* note 7 at Chapter 2.808 (February 2013); *B.A.*, *supra* note 8.

¹¹ Federal (FECA) Procedure Manual, *supra* note 7 at Chapter 2.808.5.b (1) (March 2017); *James Kennedy, Jr.*, 40 ECAB 620, 626 (1989).

¹² *Id.*

¹³ *Eugenia L. Smith*, 41 ECAB 409, 413 (1990).

OWCP accepted appellant's claim for fracture of the neck of the right femur, strain of the right pelvis, stress fracture of the right femur, bursitis of the right hip, peri-prosthetic fracture around prosthetic joint on the right, and closed fracture of the right femur. By decision dated May 2, 2017, it denied her claim for an additional schedule award finding that he had not reached MMI based on Dr. Kaplan's report.

OWCP referred appellant to Dr. Kaplan to determine appellant's permanent impairment for schedule award purposes. In his February 23, 2017 report, Dr. Kaplan reviewed appellant's February 13, 2017 bone scan and found this scan demonstrated a persistent uptake surrounding the hardware of the right femur from the total hip replacement with possible loosening of the component. He further recommended additional evaluation of appellant's hip replacement by the appropriate subspecialty prior to determining that appellant had reached MMI. Dr. Kaplan also noted that appellant had experienced a functional decline. He found that further evaluation of the total hip arthroplasty was necessary prior to permanent impairment rating for schedule award purposes as he could not determine whether appellant was at MMI based on the evidence before him.

Proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter.¹⁴ While the claimant has the responsibility to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence. It has the obligation to see that justice is done.¹⁵ Accordingly, once OWCP undertakes to develop the medical evidence further, it has the responsibility to do so in a manner that will resolve the relevant issues in the case.¹⁶ If the opinion is vague, speculative, incomplete, or not rationalized, it is its responsibility to secure a supplemental report to correct the defect.¹⁷ OWCP should prepare a statement of accepted facts to include all accepted injuries. The case shall then be forwarded to Dr. Kaplan for a supplemental report in which he addresses whether appellant has reached MMI and whether he has additional permanent impairment in accordance with the sixth edition of the A.M.A., *Guides* due to all of his accepted employment injuries. Dr. Kaplan should provide additional explanation of the diagnostic tests of record and if necessary, he should obtain additional testing to determine the status of appellant's hip replacement. The case shall be remanded for further factual and medical development. Following this and such further development deemed necessary, OWCP shall issue a *de novo* decision on appellant's schedule award claim.

¹⁴ See *B.A.*, *supra* note 8; *Vanessa Young*, 55 ECAB 575 (2004); *John J. Carlone*, 41 ECAB 354 (1989).

¹⁵ See *B.A.*, *supra* note 8; *Richard E. Simpson*, 55 ECAB 490 (2004); *Carlone*, *id.*

¹⁶ See *B.A.*, *supra* note 8; *R.M.*, Docket No. 16-0147 (issued June 17, 2016); *Melvin James*, 55 ECAB 406 (2004).

¹⁷ *G.K.*, Docket No. 12-0058 (issued December 11, 2012); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.9.c & j (June 2015) (a second opinion physician should provide a complete evaluation of the claimant's conditions. If the second opinion lacks rationale or fails to address the specific medical issues, OWCP should seek clarification from that physician).

CONCLUSION

The Board finds that this case is not in posture for decision.¹⁸

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated August 31 and May 2, 2017 are set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: May 25, 2018
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board

¹⁸ Given the disposition of this matter in Issue 1, Issue 2 is moot.